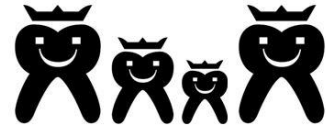


MAIN ST DENTAL CLINIC

415 MAIN ST, LILYDALE 3140

TELEPHONE: 9735 1588



DR. PETER MALIN DR. ALEX SHEN DR. ANA EROR DR. MARIA PHAM DR. SARAH QUEK DR. LAVONNE KONG

Welcome to Main St Dental Clinic. Please take some time to answer these questions as completely as possible. The information you provide will ensure you receive the best possible dental treatment. If you have any questions or concerns please do not hesitate in talking to any of our staff. Thank You.

PATIENT INFORMATION

Name: [Mr. Mrs. Ms. Miss. Master] _____
(Surname) (Given Names)

Preferred Name : _____ Date of Birth: _____
(if different from above)

Home Address: _____

Postal Address: _____ Postcode: _____

Telephone [Home] _____ Telephone [Mobile] _____

Who recommended you to our Dental Rooms? _____

Person responsible for fees (if different from above): _____

I UNDERSTAND THAT FEES ARE PAYABLE IN FULL AT TIME OF SERVICE AND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES NOT COVERED BY PRIVATE HEALTH INSURANCE.

Signature of Responsible Party _____ Date: _____

GENERAL INFORMATION

PLEASE TICK APPROPRIATE ANSWER AND DETAIL IF NECESSARY.

Have you ever had complications either during or following dental treatment? YES NO
Details: _____

Is there a specific reason for today's visit? YES NO
Details: _____

Do you have any concerns about receiving dental treatment? YES NO
Details: _____

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